California Rural Health Policy Council

2nd Annual Report
to the
California Legislature

February 1, 2000

Gray Davis, *Governor*
State of California

Grantland Johnson, *Secretary*
California Health and Human Services

Fred I. Johnson, *Executive Director*
California Rural Health Policy Council

California Rural Health Policy Council
2nd Annual
Report to the California Legislature

Fiscal Year 1998-1999

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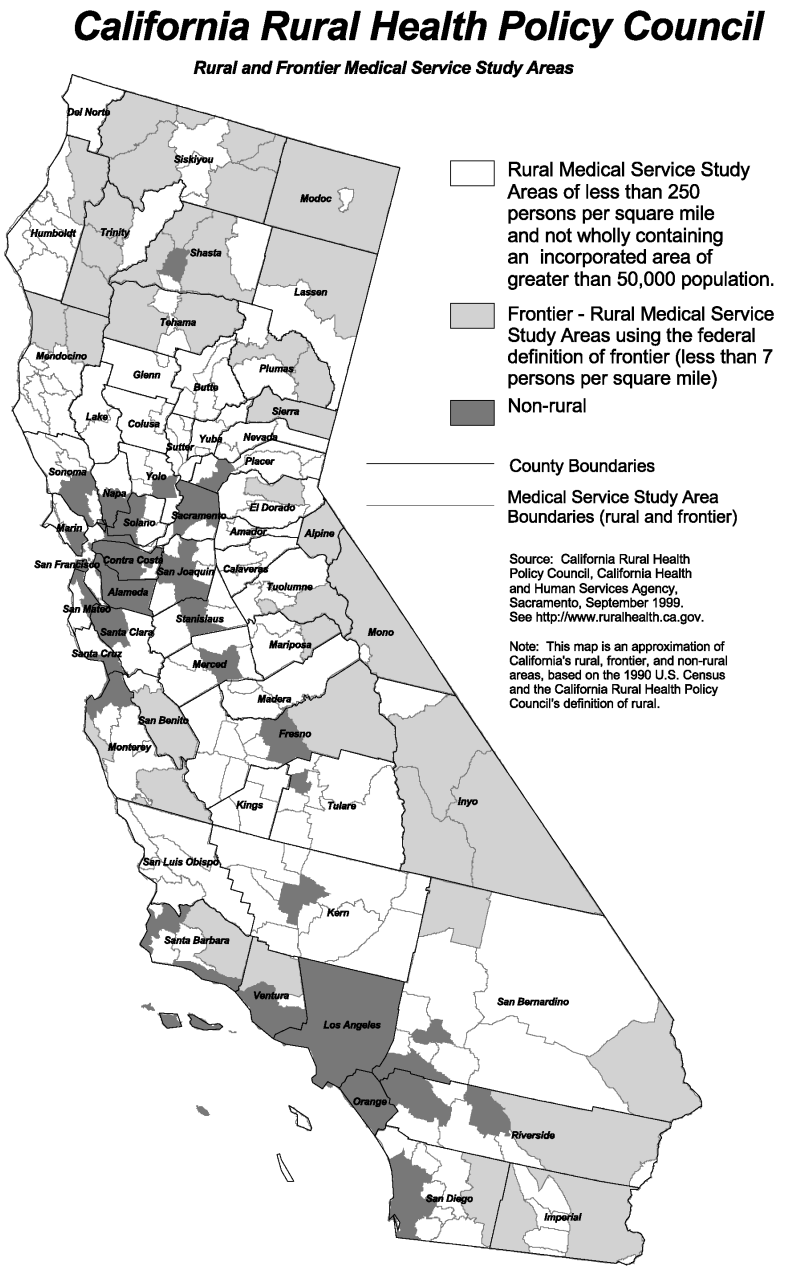
INTRODUCTION

· Background



Under the administration of Governor Gray Davis and Health and Human Services Secretary Grantland Johnson, the California Rural Health Policy Council has been recognized for the valuable and important contribution it makes throughout California as the "Focal Point" on Rural Health within state government and for the innovative model this Council represents nationally.

Based upon the most recent (1990) United States Census, rural areas encompass 13% of California's population and 80% of its geography. All but three of California's counties have some defined rural area within their boundaries. Twenty-nine of the fifty-eight counties are considered entirely rural under the California Rural Health Policy Council's definition. Some of these counties represent the most difficult areas in which to deliver services, being geographically remote, isolated during bad weather, and economically disadvantaged. Government spending, especially for health care, represents a significant portion of the economy in these areas.

Recognizing that rural areas of California were indeed different from urban metropolitan areas and required targeted attention, Assembly Bill 911 (Chapter 305/1995) became law. This landmark rural health legislation directed that a State Office of Rural Health or an "alternative organizational structure" be established as the focal point on rural health activities within State government. In response, the California Rural Health Policy Council was established on March 8, 1996, consisting of the directors of the Department of Health

Services, the Office of Statewide Health Planning and Development, the Department of Mental Health, the Department of Alcohol and Drug Programs, and the Emergency Medical Services Authority. The Policy Council then proceeded to carry out the various actions detailed in AB 911, in order to coordinate rural health policy and activities in California.

In 1998 Assembly Bill 2780 (Chapter 310/1998) added the Managed Risk Medical Insurance Board to the Policy Council. It also authorized a third year of California Rural Health Policy Council grants, and added a required annual workplan and annual report to the Legislature. In other budget actions, the four loaned staff positions in the California Rural Health Policy Council (CRHPC) Office, assigned to manage the Policy Council's support functions to rural areas, were made permanent. These actions reflect the continuing commitment of both the Legislature and the Administration to addressing California's rural health issues.

Recently, AB 1107 (Chapter 146/1999) deleted sunset dates for the Rural Health Policy Council Grants Program thereby establishing an ongoing program, subject to appropriation of funds for this purpose in the annual State budget.

▪ Purpose of this Report

Pursuant to Chapter 310/1998, the Policy Council must adopt an annual workplan and report annually on prgress towards meeting specific performance objectives that the Policy Council adopts for each workplan area. The second annual workplan and report is due to the Legislature on February 1, 2000.

It is the Policy Council's intent to make this report as useful and as accessible to the public as possible. Included at the end of this report is a form for your suggestions and comments, which you are encouraged to complete and return to us by mail or FAX. In order to ensure easy access, all publications of the CRHPC Office, including this report, can be obtained in print from the CRHPC Office at (916) 654-2991, (800) 237-4492, or may be viewed electronically and/or downloaded from the CRHPC website (www.ruralhealth.ca.gov)

EXECUTIVE SUMMARY

▪ Process to Date

The California Rural Health Policy Council efforts in working with rural health issues and communities could be characterized in three phases: developing structures for communication, identifying developing issues, and addressing the identified issues. Each phase has had a corresponding activity - dialogue, analysis and action -- that has led to the next phase. The use of dialogue, objective analysis and collaborative efforts characterize the operating approach adopted by the Policy Council in its work.
From this process emerged a clear vision and mission as well as a core set of issues that appeared central to the Policy Council's scope of responsibility and resulted in the Policy Council adopting a statement of its Vision, Mission and Major Policy Issue Areas (see page 5). It also adopted a Project Workplan to guide the work of the Policy Council into the future, and to bring as many of these ideas to reality as possible.

▪ Transforming Vision to Action

The Policy Council envisions changes in how State agencies will conduct business in rural areas. The Policy Council has directed the Interdepartmental Rural Health Coordinating Committee (IRHCC), composed of approximately twenty managers from seven state agencies, to establish an agenda for specific areas of the Project Workplan each year, and to develop recommendations to address the issues raised. To date the IRHCC has addressed the Audit Consolidation process; the Resource Directory; development and administration of the Policy Council grant programs; as well as participating in this 2nd Annual Report to the Legislature.
This, the 2nd Annual Report to the Legislature, records Policy Council and Office staff outcomes achieved during FY 1998-1999 and future actions planned for FY 1999-2000.

▪ Annual Workplan, Performance Objectives and Annual Report

Pursuant to California Health and Safety Code Section 1179.5, the CRHPC Office is to develop an annual workplan that is to be adopted by the Policy Council. The workplan is to describe how the Policy Council will meet specific, measurable performance objectives. The workplan is to be designed to further the goals of the Policy Council to improve access to, and the quality of, health care in rural areas. The workplan must address how the Policy Council intends to address, at a minimum, all the following topics (which correspond directly to the major areas as originally adopted in the Policy Council's Project Workplan):

1. Increased standardization and consolidation of financial and statistical reporting, billing, audits, contracts, and budgets.
2. Network delivery and integrated delivery systems.
3. Streamlining the regulatory process.
4. Assessing the impact of managed care in rural communities.

5. Reviewing and proposing changes necessary to improve current funding issues.
6. Increasing the use of technology.
7. Supporting innovative efforts to improve patient transportation.
8. Providing strategic planning for local communities.
9. Improving communication between the state and rural providers.
10. Increasing workforce availability in rural areas.

The Policy Council is to provide an annual report to the chairs of the fiscal and policy committees of the Legislature on the outcomes achieved during the preceding twelve months and what changes it will incorporate into the workplan for the following year. The first report was due and filed with the Legislature by February 1, 1999. The 2nd Annual report is due to the Legislature by February 1, 2000.

· Next Steps

The Policy Council will review the major policy issue papers and the possible approaches presented (Appendix 2) and consider assignment of issues to staff in a department or group of departments, which will continue the process of research, analysis, and dialogue between the State staff and the affected local entities, with the expectation that improved systems and services in rural areas will result.

The Policy Council workplan will be monitored by measuring progress in achieving results established by the adopted performance objectives. Progress towards implementing the action plans will be reviewed by the responsible CRHPC departments, and discussed periodically by the Policy Council.

The Policy Council will continue to hold quarterly public meetings in partnership with other health related associations/organizations in various locations throughout California in order to provide ongoing opportunities for public comment on emerging issues and to update the public on CRHPC activities. By these means, the Policy Council will continue its strong commitment to improving communication between the state and rural providers.

The Planned Activities for FY 1999-2000 presented in the Policy Council Office workplan represent the performance objectives to be met by Policy Council staff. Additional opportunities, as appropriate, will be acted upon.

California Rural Health Policy Council

Vision, Mission, and Major Policy Issue Areas

(Adopted 12/97, Revised 12/98)

VISION

Residents of rural communities in California will experience improved health status through planned improvements to their local delivery systems for health care and prevention services.

MISSION

The California Rural Health Policy Council will advance this vision by ensuring that its State agencies continue to improve communication and cooperation with one another, working in a team approach with rural communities to address the health care issues they face.

Furthermore, the California Rural Health Policy Council envisions an ideal rural health care delivery system of the future as:

- fully integrating locally defined health and prevention related services;
- maintaining broad community involvement, collaboration, and acceptance; and
- using effective strategic local planning, that focuses on measurable outcomes that seek continuous improvement to the overall health status of the entire community.

The California Rural Health Policy Council will support communities in designing, developing and achieving their goals by promoting responsive, supportive and timely actions by State agencies, the Legislature, counties, statewide organizations and private foundations. This support could take many forms, by:

- providing expertise, data and technical assistance to rural providers in planning, developing and implementing successful health care delivery systems;
- discussing and redrafting State regulations that may hinder rural providers from delivering the most efficient and appropriate services to their communities;
- streamlining State funding and administrative processes; and
- working with other public and private funders to ensure that resources are targeted in the most efficient and least duplicative ways, and that the gaps in services are filled to the greatest extent possible.

MAJOR POLICY ISSUE AREAS

- Standardization and Consolidation
- Network Development/Integrated Delivery Systems
- Regulations
- Managed Care
- Funding
- Technology
- Program-specific Reviews
- Outcome-based State Management
- Strategic Planning for Local Communities
- Transportation
- Communication
- Workforce Availability

POLICY CONSIDERATION

- **Overview**
  - The California Rural Health Policy Council presents the major policy issue papers in Appendix 2 in order to summarize the status of the issues as voiced to the Council by many constituents of California's rural health field. Often these papers present views stated by the rural health providers, and those views may or may not be shared by the Policy Council.
  - The Policy Council envisions reviewing these papers and adopting approaches for each of these issues. The Council will consider prioritization of these issues and assignment to a department or group of departments that will continue the process of research, analysis, and dialogue between the State staff and the affected local entities, with the expectation that improved systems and services in rural areas will result.
  - Many of the possible approaches involve seeking federal and state waivers or legislation, or setting up an exception process for providers in rural areas.
- **Principles and Assumptions**
  - Members of both the Policy Council and the rural health community believe that the overarching goal of State and federal programs is to improve the health status of residents and to maintain access to health care services in California's rural areas.
  - State departments on the Policy Council believe that the people living and working in rural communities are in the best position to identify their needs and to work collaboratively with State programs to address those needs.
  - State departments on the Policy Council will consider pursuing federal waivers and/or state and federal legislative or regulatory changes, when necessary and appropriate.
  - State departments on the Policy Council will pursue changes to the administrative processes under their authority, when necessary and appropriate.
  - Reducing costs associated with state administrative requirements is desirable, so that the savings can be directed to services for residents in rural communities.
  - State departments on the Policy Council recognize the critical role-played by rural health providers in providing access to health services for rural residents.
  - Rural service delivery systems are strengthened when State programs recognize and plan specific provisions for "safety net" providers in rural areas.

California Rural Health Policy Council Office
2nd Annual
REPORT ON PERFORMANCE OBJECTIVES
Fiscal Year 1998 - 1999

This section of the report is respectfully submitted pursuant to Health and Safety Code Section 1179.5, which states, "The Rural Health Policy Council shall provide an annual report to the chairs of the fiscal and policy committees of the Legislature on the outcomes achieved by the office during the preceding 12 months and what changes it will incorporate into the workplan for the following year."

Described below are the five core areas of service provided by the 4.0 Full Time Equivalent (FTE) staff that constitutes the CRHPC Office. Within each area are the major systems or projects currently in operation. Each system has been reviewed and objectives measured for FY 1998-99 and planned for FY 1999-00.

Office Outcomes Achieved in FY 1998-1999:

1. Information Services

Provide timely information in both electronic Internet based and in hard copy on upcoming events, funding opportunities, employment opportunities, technology, demographics, newsletters, and publications on rural hospitals, rural clinics and on our rural jobs available.

a. Published and mailed five issues of the "Rural Health Newscast" to an average of 1,600 constituents during FY 1998-99.

b. Redesigned the CRHPC database containing service requests, issues and rolodex to include Medical Service Study Area data.

c. Updated the CRHPC database records and Email addresses to enhance our ability to send the "Rural Health Newscast" and other messages to constituents by group E-mail.

d. All CRHPC publications are posted on the CRHPC website and are downloadable.

e. Website links were tested and confirmed at the time the hyperlink was established.

f. Created and distributed to rural constituents:
   (1) Maps of census tracts and MSSA's.
   (2) Plotted rural health clinic and hospital sites.
   (3) All data map requests were completed.

g. Maintained toll-free number (California only) for access to the CRHPC

Office. Office staff responded as rapidly as possible to all calls received.

2. Coordination

Work with rural residents and a variety of public and private rural health-related entities to promote meaningful communication and collaboration and help to keep the public "in the loop."

a. Format of most CRHPC public meetings has been changed to include educational presentations of interest to rural constituents.

b. All CRHPC public meetings were convened in partnership with other organizations:

- 11/98 California State Association of Counties Annual Conference - San Diego. Joint public meeting of the CRHPC, California Rural Development Council and USDA Rural Development
- 3/99 California Healthcare Association/Rural Healthcare Centers' Annual Rural Healthcare Symposium and the California State Rural Health Association General Meeting - Fish Camp
- 5/99 National Rural Health Association's Annual National Conference - San Diego
- 10/99 Regional Council of Rural Counties Annual Fall Conference - Lake Tahoe
- 12/99 California State Association of Counties Annual Conference - Monterey

c. Legislative reporting requirements for FY 1998-99 were met.

d. All constituent issues received during FY 1997-98 were acted on by the CRHPC Office prior to December 1998.

e. All constituent issues received during FY 1998-99 were acted upon by the CRHPC Office prior to September 30, 1999.

f. Attended various meetings and made presentations to:

- Joint meeting of the California State Senate Rural Health Caucus and the California State Assembly Rural Health Caucus
- County Health Executives Association of California
- Regional Council of Rural Counties
- County Medical Services Program
- California Rural Development Council
- California State Rural Health Association
- California Healthcare Association/Rural Healthcare Center Board
- California Telehealth Telemedicine Center Board
- Developing Rural Integrated Systems Council

· Northern California Rural Health Roundtable
· Rural Community Assistance Corporation
· National Rural Health Association Planning Committee
· Statewide Health Occupations Advisory Committee
· Emergency Medical Services Authority Planning Committee
· Northern California Health Alliance

3. Assistance

Help to coordinate resources between providers by bringing those with particular expertise together with those who need their technical assistance.

a. 145 service requests were recorded and tracked by the Issues Coordinator. Numerous others were received and responded to but not recorded in the CRHPC database.

b. 99.9% of the services requests recorded were resolved to the satisfaction of the constituent.

c. As of 6/30/99 a total of 307 site visits have been completed, as follows:
· 62 Hospitals
· 96 Clinics
· 36 County Health Agencies
· 4 Skilled Nursing Facilities - Freestanding
· 55 Public Associations/Organizations
· 35 Private Organizations
· 11 Foundations
· 8 Others

d. Responded to 100% of all requests for assistance.

4. Workforce Development

The Council's "Rural Health Jobs Available" is an interactive and searchable database located on the Council website and is dedicated to helping the rural health employer recruit qualified personnel in the areas of patient care, ancillary services, and administrative positions in rural hospitals, rural clinics, local government and long-term care facilities. As a member of the National (47 State) Rural Recruitment and Retention (3-R Net) Program, based at the University of Wisconsin, these positions are listed on the World Wide Web. The rural health providers can submit listings "online" or by fax for posting on this "no charge" service located at www.ruralhealth.ca.gov/ruraljob/ The primary goal is to advertise available employment opportunities and to connect the job seeker directly with the employer.

a. Listed 890 jobs as of 6/30/99.

b. Published the first Annual Report on the Rural Jobs Available Service.

5. Funding

Provide information on rural health funding opportunities and maintain the Internet based CRHPC "Funding Clearinghouse" at www.ruralhealth.ca.gov./funding.htm/ Award grants to eligible rural health providers on a competitive basis, subject to appropriation of funds in the State budget.

a. Established a "Funding Clearinghouse" and listed 160 different funding sources as of 6/30/99.

b. Published feature articles on fourteen funding opportunities in issues of the "Rural Health Newscast" published during FY 1998-99.

c. Offered administrative support to DHS for CRHPC Hospital Grants and to OSHPD for CRHPC Small grants, while administering OSHPD's Capital Grants program for FY 1998/99.

Office Activities Planned for FY 1999-2000:

1. Information Services

Provide timely information in both electronic Internet based and in hard copy on upcoming events, funding opportunities, employment opportunities, technology, demographics, newsletters, and publications on rural hospitals, rural clinics and on our rural jobs available.

a. Publish six issues of the "Rural Health Newscast" and distribute to an average of 1,700 constituents during FY 1999/2000

b. Continue redesign of CRHPC database to include OSHPD clinic and hospital data and DHS licensing data. Update MSSA and census tract data.

c. Create mass E-mail capability.

d. Continue to post all CRHPC publications on the CRHPC website.

e. Test all CRHPC website links periodically (every other month) to ensure that they are still current.

f. Continue to respond in a favorable and timely manner to constituent requests.

g. Continue to be highly customer service oriented and respond to all calls as rapidly as possible.

h. Publish report on California General Acute Care Hospitals in Rural and Non-rural Areas - Selected Utilization and Financial Data 1996, 1997, and 1998.

i. Publish report on Licensed Nonprofit Primary Care Clinics in Rural Areas - Selected Patient, Utilization and Financial Data 1995, 1996, and 1997.

2. Coordination

Work with rural residents and a variety of public and private rural health-related entities to promote meaningful communication and collaboration and help to keep the public "in the loop."

a. Continue to capture opportunities, which increase attendance at CRHPC public meetings.

b. Convene all CRHPC public meetings in conjunction with meetings of other organizations/associations.

c. Review the CRHPC Workplan for modification, ratification, adoption, and implementation.

d. Meet legislative reporting requirements.

e. Act on all constituent issues received during FY 1999/2000 by the CRHPC prior to September 30, 2000.

f. Continue to attend and participate in discussions and make presentations to various organizations and associations.

g. Collaborate and communicate with federal agencies and other states as appropriate.

h. Attend and participate in nationally focused meetings outside of California, such as the National Rural Health Association, National Public Health Association, National Association of Rural Health Clinics, meetings sponsored by the federal Office of Rural Health Policy, and others subject to approval of out-of-state travel.

i. Continue to participate on boards/councils of rural health-related organizations/associations.

j. Mail a Constituent Satisfaction Survey to approximately 1,700 rural constituents, publish results and adopt an action plan responsive to the rural constituents' comments.

3. Assistance

Help to coordinate resources between providers by bringing those with particular expertise together with those who need their technical assistance.

a. Continue to enter and track 100% of the service requests received.

b. Resolve at least 95% of the service requests received to the satisfaction of the constituent.

c. Continue to make first-time CRHPC site visits to rural providers and respond to all requests for site visits.

d. Continue to respond to 100% of all requests for assistance.

4. Workforce Development

List positions on our "Rural Health Jobs Available" our interactive and searchable database dedicated to helping rural health employers recruit qualified personnel in the areas of patient care, ancillary services, and administrative positions in rural hospitals, rural clinics, local government and long-term care facilities. As a member of the National (47 State) Rural Recruitment and Retention (3-R Net) Program, based at the University of Wisconsin, these positions are listed on the World Wide Web. The rural health providers can submit listings "online" or by fax for posting on this "no charge" service located at www.ruralhealth.ca.gov/ruraljob/. The primary goal is to advertise available employment opportunities and to connect the job seeker directly with the employer.

a. List 1,200 jobs by 6/30/2000.

b. 1,000 of the total jobs listed will be filled by 6/30/2000.

c. Respond to 750 information and/or employment inquiries from foreign-born (J-1 eligible) physicians seeking employment in rural California.

d. Publish summary report on California's Rural Health Jobs Available Service as of 6/30/2000.

5. Funding

Provide information on funding opportunities to rural health providers and maintain the Internet based CRHPC "Funding Clearinghouse" at www.ruralhealth.ca.gov/funding.htm/. Award grants to eligible rural health providers on a competitive basis, subject to appropriation of funds in the State budget.

a. Continue expansion of the "Funding Clearinghouse" by listing and/or providing hyperlinks to at least 30 additional rural funding sources by 6/30/2000.

b. Publish at least 16 funding opportunities in the “Rural Health Newscast” during FY 99/2000.

c. Continue to promote inclusion to the CRHPC Office in the OSHPD grant making process, which result in CRHPC Small Grants awards.

d. CRHPC award $1.047 million in Small Grants to rural health providers during FY 99/2000

RURAL HEALTH GRANT PROGRAMS ACTIVITY
Statistical Summary
Small Grants

	FY 1996-97	FY 1997-98	FY 1998-99	FY 1999-2000
RFA packets mailed	00	300+	213	200+
Applications received	57	120	121	130
Grants awarded	40	55	54	43
Total awarded	$1,000,000	$1,370,471	$1,202,811	$1,044.184
Range of awards	$25,000	$22,990 - $25,000	$7,330 - $23,256	$8,000 - $25,000

Collaborative Grants

	FY 1996-97	FY 1997-98	FY 1998-99	FY 1999-2000
RFA packets mailed	--	N/A	N/A	N/A
Applications received	34	--	--	--
Grants awarded	8	--	--	--
Total Awarded	$1,485,601	--	--	--
Range of awards	$117,667 - $200,000	N/A	N/A	N/A

RURAL HEALTH GRANT PROGRAMS ACTIVITY
Statistical Summary
Continued

Hospitals Grants

	FY 1996-97	FY 1997-98	FY 1998-99	FY 1999-2000
Number of eligible applicants & RFA packets mailed	75	75	72	N/A - Merged into Small Grants program (see previous)
Applications received	30	46	44	
Grants awarded	30	16	44	
Total awarded	$2,500,00	$528,990	$634,189	
Range of awards	$1,962 - $325,778	$3,000 - $25,000	$5,581 - $23,256	N/A
Total awarded each year	$4,985,801	$1,899,461	$1,837,000	$1,044,184

NOTES:

- This grant program is authorized in Health and Safety Code Section 1179.3.
- Total funds appropriated in each fiscal year are as follows:

  FY 1996-97 equaled $5,000,000
  FY 1997-98 equaled $1,903,000 (Reduced by $3,097,000 from FY 96/97)
  FY 1998-99 equaled $1,837,000 (Reduced by $66,000 from FY 97/98)
  FY 1999-2000 equaled $1,047,000 (Reduced by $790,000 from FY 98/99)
- FY 1999-2000 Effective 8/17/99, the Rural Hospital Services Grant program has been merged into the Small Grants program and rural hospitals are eligible to apply for these funds on a competitive basis.
- The Rural Health Services Small Grants awards may be made up to $25,000. Eligible applicants are to address problems of access to quality health care in rural areas and how to compensate public and private health care providers for costs associated with the direct delivery of patient care.
- The fund source is the Cigarette and Tobacco Surtax Fund created by Proposition 99. The purpose of these funds is to deliver health and medical services in rural areas of the State. The funds are used exclusively for medical and hospital treatment for patients who cannot afford to pay for services and for whom payments will not be made though private or public programs. Several providers have testified to the immediate benefits of the grants program; for example, a clinic can open on Saturdays in a rural area where residents are migrant and seasonal farmworkers who cannot seek health care during the week.

California Rural Health Policy Council
2nd Annual
REPORT ON PERFORMANCE OBJECTIVES
Fiscal Year 1998 - 1999

The Council section of the report is respectfully submitted pursuant to Health and Safety Code Section 1179.5. This section lists 12 major policy issue areas (Appendix 2) identified at public meetings conducted by the Council at various locations throughout California. The Council will review these areas then discuss, affirm, prioritize and ultimately assign to members of the Interdepartmental Rural Health Coordinating Committee for appropriate action.

Council Outcomes Achieved in FY 1998-1999:

1. Standardization and Consolidation

In order to maximize their funding opportunities, rural health providers must comply with administrative requirements from approximately one hundred different health programs that the State administers, monitors and audits, most often with separate policies, procedures and regulations. Many in the rural health field would like to see a consolidation of these programs, so that less funding is spent on administration and more funding is available for direct patient services.

a. The DHS Deputy Director over Audits and Investigations has increased communication, access to and responsiveness from state A & I officials and regularly attends CRHPC Public Meetings.

b. Possible approaches to addressing standardization and consolidation have been identified along with the associated pros and cons.

2. Network Development/Integrated Delivery Systems

In order to maintain services and access in rural areas in an era of rapid change in the health care market, rural health providers have expressed the need for financial and/or technical support from State departments for developing provider networks and integrating delivery systems in rural areas. Possible approaches to addressing Network Development/Integrated Delivery Systems have been identified along with the associated pros and cons.

3. Regulations

Rural health providers perceive that State regulations are often designed for urban-based health providers. Moreover, their perception is that State interpretation and application of these regulations are sometimes inconsistent. Possible approaches to addressing regulations have been identified along with the associated pros and cons.

4. Managed Care

The ability of rural health providers to compete successfully in a managed care environment is of concern to many rural providers. Possible approaches to

addressing Managed Care have been identified along with the associated pros and cons.

5. Funding

Rural health providers have limited resources and must deal with problems associated with uncompensated care and the lack of economies of scale. They often express the need for additional funding to meet the needs of their communities.

a. Possible approaches to addressing Funding have been identified along with the associated pros and cons.

b. "Funding Clearinghouse" designed and installed on CRHPC website with approximately 150 different funding sources for California rural health providers.

6. Technology

The revolution in electronic technology has created opportunities for telehealth and telemedicine (TH/TM) applications for rural health care providers.

a. Possible approaches to addressing Technology have been identified along with the associated pros and cons.

b. CRHPC Office has joined the State Department of Developmental Services in co-hosting a Telehealth/Telemedicine roundtable for state agencies.

c. The CRHPC Executive Director is a member of the California Telehealth Telemedicine Center's Board of Directors.

7. Program-specific Reviews

Health care delivery in rural areas may benefit from a review of certain programs. Rural counties believe that State departments could recognize the administrative and staffing limitations and lack of economies of scale present in small counties, and provide flexibility to these areas, without compromising the goals of individual programs. Possible approaches to addressing technology have been identified along with the associated pros and cons.

8. Outcome-based State Management

Many in the rural health community would prefer State departments focus more on the positive and lasting impact that their programs and funding have on rural residents and communities, and less on administrative, budget and process-related activities as indicators of program success. Possible approaches to addressing Outcome-based State Management have been identified along with the associated pros and cons.

9. Transportation

Rural residents needing medical care are frequently unable to access care because they have no transportation to the nearest medical facility. In extreme cases, they sometimes resort to calling an ambulance, which makes that Advanced Life Support/Basic Life Support (ALS/BLS) unit unavailable for true emergencies and is the highest cost method of transportation within our health care system. Possible approaches to addressing Transportation have been identified along with the associated pros and cons.

10. Strategic Planning for Local Communities

Rural communities recognize the value of strategic planning for their communities, but often do not have the resources or expertise locally to conduct it. Possible approaches to addressing Strategic Planning for Local Communities have been identified along with the associated pros and cons.

11. Communication

The lack of effective cross-department communication and coordination on rural health activities among federal, State and local departments adversely impacts rural communities.

a. "FAQ" page is updated and expanded as other departments contribute to this effort.

b. Possible approaches to addressing Communication have been identified along with the associated pros and cons.

12. Workforce Availability

Rural health providers face difficulties in recruiting clinical providers and experienced, knowledgeable administrative staff. Even if providers are successful in recruiting such individuals, the providers then face the challenge of retaining them. Possible approaches to addressing workforce availability have been identified along with the associated pros and cons.

<u>Council Activities Planned for FY 1999-2000:</u>

1. Standardization and Consolidation

In order to maximize their funding opportunities, rural health providers must comply with administrative requirements from approximately one hundred different health programs that the State administers, monitors and audits, most often with separate policies, procedures and regulations. Many in the rural health field would like to see a consolidation of these programs, so that less funding is spent on administration and more funding is available for direct patient services.

a. Ratification of a background issue paper on Standardization and Consolidation.

b. Consider possible approaches to addressing Standardization and Consolidation.

c. Adopt initial approach to be used in addressing Standardization and Consolidation.

d. Consolidate CRHPC Hospital grants program with CRHPC Rural Health Services Small Grants Program.

e. Consolidate OSHPD Rural Health Professional Loan Repayment Program with Rural Health Development Capital Grants Program

2. Network Development/Integrated Delivery Systems

In order to maintain services and access in rural areas in an era of rapid change occurring in the health care market, rural health providers have expressed the need for financial and/or technical support from State departments for developing provider networks and integrating delivery systems in rural areas.

a. Ratification of a background issue paper on Network Development / Integrated Delivery Systems.

b. Consider possible approaches to addressing Network Development/ Integrated Delivery Systems.

c. Adopt initial approach to be used in addressing Network Development/ Integrated Delivery Systems.

3. Regulation

Rural health providers perceive that State regulations are often designed for urban-based healthy providers. Moreover, their perception is that State interpretation and application of these regulations are sometimes inconsistent.

a. Ratification of a background issue paper on Regulation.
b. Consider possible approaches to addressing Regulation.
c. Adopt initial approach to be used in addressing Regulation.

4. Managed Care

The ability of rural health providers to compete successfully in a managed care environment is of concern to many rural providers.

a. Ratification of a background issue paper on Managed Care.
b. Consider possible approaches to addressing Managed Care.
c. Adopt initial approach to be used in addressing Managed Care.

5. Funding

Rural health providers have limited resources and must deal with problems associated with uncompensated care and the lack of economies of scale. They often express the need for additional funding to meet the needs of their communities.

a. Ratification of a background issue paper on Funding.
b. Consider possible approaches to addressing Funding.
c. Adopt initial approach to be used in addressing Funding.
d. Continue expansion of "Funding Clearinghouse" by listing and/or providing hyperlinks to at least 30 additional rural funding sources.

e. Award 40 Small Grants to rural health providers, up to $25,000 each for a combined total not to exceed $1,047,000.

6. Technology

The revolution in electronic technology has created opportunities for telehealth and telemedicine (TH/TM) applications for rural health care providers.

a. Ratification of a background issue paper on Technology
b. Consider possible approaches to addressing Technology.
c. Adopt initial approach to be used in addressing Technology.

7. Program-specific Reviews

Health care delivery in rural areas may benefit from a review of certain programs. Rural counties believe that State departments could recognize the administrative and staffing limitations and lack of economies of scale present in small counties, and provide flexibility to these areas, without compromising the goals of individual programs.

a. Ratification of a background issue paper on Program-specific Reviews.
b. Consider possible approaches to addressing Program-specific Reviews.
c. Adopt initial approach to be used in addressing Program-specific Reviews.

8. Outcome-based State Management

Many in the rural health community would prefer State departments focus more on the positive and lasting impact that their programs and funding have on rural residents and communities, and less on administrative, budget and process-related activities as indicators of program success.

a. Ratification of a background issue paper on Outcome-based State Management.
b. Consider possible approaches to addressing Outcome-based State Management.
c. Adopt initial approach to be used in addressing Outcome-based State Management.

9. Transportation

Rural residents needing medical care are frequently unable to access care because they have no transportation to the nearest medical facility. In extreme cases, they sometimes resort to calling an ambulance, which makes that

adavanced Life Support/Basic Life Support (ALS/BLS) unit unavailable for true emergencies and is the highest cost method of transportation within our health care system.

a. Ratification of a background issue paper on Transportation.
b. Consider possible approaches to addressing Transportation.
c. Adopt initial approach to be used in addressing Transportation.

10. Strategic Planning for Local Communities

Rural communities recognize the value of strategic planning, but often do not have the resources or expertise locally to conduct it.

a. Ratification of background issue paper on Strategic Planning for Local Communities.
b. Consider possible approaches to addressing Strategic Planning for Local Communities.
c. Adopt initial approach to be used in addressing Strategic Planning for Local Communities.

11. Communication

The lack of effective cross-department communication and coordination on rural health activities among federal, State and local departments adversely impacts rural communities.

a. Continue to expand the "FAQ" webpage with contributions from other departments.

b. Ratification of a background issue paper on Communication.

c. Consider possible approaches to addressing Communication.

d. Adopt initial approach to be used in addressing Communication.

12. Workforce Availability

Rural health providers face difficulties in recruiting clinical providers and experienced, knowledgeable administrative staff. Even if providers are successful in recruiting such individuals, the providers then face the challenge of retaining them.

a. Ratification of a background issue paper on Workforce Availability.

b. Consider possible approaches to addressing Workforce Availability.

c. Adopt initial approach to be used in addressing Workforce Availability.

APPENDICES

Appendix 1

Authorizing Statutes

Health and Safety Code Sections:

1179. The Legislature finds and declares all of the following:
(a) Outside of California's four major metropolitan areas, the majority of the state is rural. In general, the rural population is older, sicker, poorer, and more likely to be unemployed, uninsured, or underinsured. The lack of primary care, specialty providers and transportation continue to be significant barriers to access to health services in rural areas.
(b) There is no coordinated or comprehensive plan of action for rural health care in California to ensure the health of California's rural residents. Most of the interventions that have taken place on behalf of rural communities have been limited in scope and purpose and were not conceived or implemented with any comprehensive or systematic approach in mind. Because health planning tends to focus on approaches for population centers, the unique needs of rural communities may not be addressed. A comprehensive plan and approach is necessary to obtain federal support and relief, as well as to realistically institute state and industry interventions.
(c) Rural communities lack the resources to make the transition from present practices to managed care, and to make other changes that may be necessary as the result of health care reform efforts. With numerous health care reform proposals being debated and with the extensive changes in the current health care delivery system, a comprehensive and coordinated analysis must take place regarding the impact of these proposals on rural areas.
(d) Rural areas lack the technical expertise and resources to improve and coordinate their local data collection activities, which are necessary for well-targeted health planning, program development, and resource development. Data must be available to local communities to enable them to plan effectively.
(e) The Legislature recognizes the need to take a comprehensive approach to strengthen and coordinate rural health programs and health care delivery systems in order to:
(1) Facilitate access to high quality health care for California's rural communities.
(2) Promote coordinated planning and policy development among state departments and between the State and local public and private providers.

1179.1. (a) The Secretary of the Health and Welfare Agency shall establish an Office of Rural Health, or an alternative organizational structure, in one of the departments of the Health and Welfare Agency to promote a strong working relationship between state government and local and federal agencies, universities, private and public interest groups, rural consumers, health care providers, foundations, and other offices of rural health, as well as to develop health initiatives and maximize the use of existing resources without duplicating existing effort. The office or alternative organizational structure shall serve as a key information and referral source to promote coordinated planning for the delivery of health services in rural California.

(b) To the extent funds are appropriated by the Legislature, these efforts may include:
(1) Educating the public and recommending appropriate public policies regarding the viability of rural health care in California.
(2) Monitoring and working with state and federal agencies to assess the impact of proposed rules and regulations on rural areas.
(3) Promoting community involvement and community support in maintaining, rebuilding, and diversifying local health services in rural areas.
(4) Encouraging and evaluating the use of advanced communications technology to provide access to health promotion and disease prevention information, specialty expertise, clinical consultation, and continuing education for health professionals.
(5) Encouraging the development of regional health care and public health networks and collaborative efforts, including, but not limited to, emergency transportation networks.
(6) Working with state and local agencies, universities, and private and public interest groups to promote research on rural health issues.
(7) Soliciting the assistance of other offices or programs of rural health in California to carry out the duties of this part.
(8) Disseminating information and providing technical assistance to communities, health care providers, and consumers of health care services.
(9) Promoting strategies to improve health care professional recruitment and retention in rural areas.
(10) Encouraging innovative responses by public and private entities to address rural health issues.

1179.2. (a) The Health and Welfare Agency shall establish an interdepartmental Task Force on Rural Health to coordinate rural health policy development and program operations and to develop a strategic plan for rural health.
(b) At a minimum, the following state departmental directors, or their representatives, shall participate on this task force:
(1) The Director of Health Services.
(2) The Director of Statewide Health Planning and Development.
(3) The Director of Alcohol and Drug Programs.
(4) The Director of the Emergency Medical Services Authority.
(5) The Director of Mental Health.
(6) The Executive Director of the Managed Risk Medical Insurance Board.
(c) The task force shall review and direct the activities of the Office of Rural Health or the alternative organizational structure, as determined by the Secretary of the Health and Welfare Agency.
(d) The task force shall establish appropriate mechanisms, such as ad hoc or standing advisory committees or the holding of public hearings in rural communities for the purpose of soliciting and receiving input from these communities, including input from rural hospitals, rural clinics, health care service plans, local governments, academia, and consumers.
(e) By May 1, 1996, the Secretary of the Health and Welfare Agency shall report to the Chair of the Joint Legislative Budget Committee and the Chairs of the Senate and Assembly Health Committees, and at that time submit the strategic plan developed by the task force. This strategic plan may include but shall not be limited to the following

elements:
(1) The status of establishing an Office of Rural Health or alternative organizational structure.
(2) The roles and responsibilities of that office or alternative organizational structure.
(3) The mechanism for ongoing input to the office or alternative organizational structure by members of the public, rural health care providers, rural hospitals, health care service plans, and local governments.
(4) The identification of all departments and agencies with significant program or funding responsibility for rural health care.
(5) A detailed plan to consolidate and coordinate the activities of the programs identified pursuant to paragraph (4) to better meet the health care needs of rural residents.

1179.3. (a) (1) The California Rural Health Policy Council shall develop and administer a competitive grants program for projects located in rural areas of California.
(2) The California Rural Health Policy Council shall define "rural area" for the purposes of this section after receiving public input and upon recommendation of the Interdepartmental Rural Health Coordinating Committee and the Rural Health Programs Liaison.
(3) The purpose of the grants program shall be to fund innovative, collaborative, cost-effective, and efficient projects that pertain to the delivery of health and medical services in rural areas of the state.
(4) The California Rural Health Policy Council shall develop and establish uses for the funds to fund special projects that alleviate problems of access to quality health care in rural areas and to compensate public and private health care providers associated with direct delivery of patient care. The funds shall be used for medical and hospital care and treatment of patients who cannot afford to pay for services and for whom payment will not be made through private or public programs.
(5) The Office of Statewide Health Planning and Development shall administer the funds appropriated by the Legislature for purposes of this section. Entities eligible for these funds shall include rural health providers served by the programs operated by the departments represented on the California Rural Health Policy Council, which include the State Department of Alcohol and Drug Programs, the Emergency Medical Services Authority, the State Department of Health Services, the State Department of Mental Health, the Office of Statewide Health Planning and Development, and the Managed Risk Medical Insurance Board. The grant funds shall be used to expand existing services or establish new services and shall not be used to supplant existing levels of service. Funds appropriated by the Legislature for this purpose may be expended in the fiscal year of the appropriation or the subsequent fiscal year.
(b) The California Rural Health Policy Council shall establish the criteria and standards for eligibility to be used in requests for proposals or requests for application, the application review process, determining the maximum amount and number of grants to be awarded, preference and priority of projects, compliance monitoring, and the measurement of outcomes achieved after receiving comment from the public at a meeting held pursuant to the Bagley-Keene Open Meeting Act (Article 9 (commencing with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2 of the Government Code).
(c) The Office of Statewide Health Planning and Development shall periodically report to the California Rural Health Policy Council on the status of the funded projects. This information shall also be available at the public meetings.

1179.5. (a) The Rural Health Policy Office within the Office of Statewide Health Planning and Development serving as staff to the California Rural Health Policy Council shall develop an annual workplan, which is adopted by the council. The workplan shall describe how the council shall meet specific, measurable performance objectives. The workplan shall be designed to further the goals of the California Rural Health Policy Council to improve access to, and the quality of, health care in rural areas.

(b) The workplan required under subdivision (a) shall include information on how the council intends to address, at a minimum, all of the following topics:

(1) Increased standardization and consolidation of financial and statistical reporting, billing, audits, contracts, and budgets.

(2) Network delivery and integrated delivery systems.

(3) Streamlining the regulatory process.

(4) Assessing the impact of managed care in rural communities.

(5) Reviewing and proposing changes necessary to improve current funding issues.

(6) Increasing the use of technology.

(7) Supporting innovative efforts to improve patient transportation.

(8) Providing strategic planning for local communities.

(9) Improving communication between the state and rural providers.

(10) Increasing workforce availability in rural areas.

(c) The California Rural Health Policy Council shall provide an annual report to the chairs of the fiscal and policy committees of the Legislature on the outcomes achieved by the office during the preceding 12 months and what changes it will incorporate into the workplan for the following year. The first report pursuant to this section shall be provided to the Legislature by February 1, 1999.

Major Policy Issue Areas

1 Standardization and Consolidation

Summary of the Issue

In order to maximize their funding opportunities, rural health providers must comply with administrative requirements from approximately one hundred different health programs that the State administers, monitors and audits, most often with separate policies, procedures and regulations. Many in the rural health field would like to see a consolidation of these programs, so that less funding is spent on administration and more funding is available for direct patient services.

Background/History

Historically, federal and State budgets appropriate funding for a wide variety of specific health-related programs. Some of the issues with the current system raised by the rural health providers involve how the awards are made, the high cost of administering the awards and the ability to meet actual rural needs with these funds, as follows:

- Typically, these programs arise from specific unmet needs identified in urban areas. These targeted funds may or may not be effective in rural areas. Even when appropriately targeted, the allocation of funding available to each provider is usually based on criteria relevant to urban areas. The impression among rural providers is that these allocation processes result in awards to rural areas that may not cover the costs of complying with the numerous administrative requirements associated with each funding source.

- The categorical funding streams lead to higher costs in administering the grants. Each funding source requires separate contracts, separate line item budgets, separate staffing by the recipient, separate statistical reporting, separate invoicing, separate financial accounting and reporting, separate program reviews for compliance, separate auditing, and lastly, a separate appeals process.
- Finally, the categorical process is perceived by many rural providers as limiting the ability of rural communities to use the funds where most needed or to respond quickly enough when local needs change.

Some efforts have been made to change current practice. Legislative activity led to AB 1741 that allowed pilot counties to test consolidation of some of these programs in innovative ways. Also, the Department of Health Services continues to pilot a cost allocation system in Placer County, which should soon yield results. These past and current efforts should be reviewed for applicable lessons.

Desired Outcomes

- The CRHPC is committed to encouraging State departments to standardize and consolidate requirements in the areas of statistical reporting, billing and financial reporting, audits, contracts, and budgets, both within and across departments, to the greatest degree possible.
- Many in the rural health community support efforts to move towards a simplified

block grant approach for rural areas, with appropriate safeguards on allowable expenditures, but also with performance objectives tied to meaningful outcomes, such as improvements in health status indicators.

Possible Approaches

A. State departments could pursue waivers from the federal government to streamline, simplify and consolidate administrative requirements.

PROS: This would increase the authority of State departments to implement streamlining efforts.

CONS: Federal waivers may not be available for many of the changes needed. Waiver applications take intensive staff efforts on the part of State departments and may not be successful at the federal level.

B. Where appropriate, State departments could review and support efforts through federal and State legislation to make the categorical funding streams more responsive to rural needs.

PROS: Would be responsive to requests from many rural health providers and counties. Would pass decision-making to the local level, which has been assumed in other State realignment efforts to be best positioned in determining local needs. Could result in reduced administrative workloads within State departments.

CONS: Would be a lengthy effort to work through legislative process.

C. State departments could study past and current re-design efforts, such as the Placer County pilot, and implement the successful aspects of those efforts.

PROS: State departments would use experience from past successful efforts.

CONS: Would rely on only past and current experience, leaving out potential models for which no experience exists.

2 Network Development/Integrated Delivery Systems

Summary of the Issue

In order to maintain services and access in rural areas in an era of rapid change occurring in the health care market, rural health providers have expressed the need for financial and/or technical support from State departments for developing provider networks and integrating delivery systems in rural areas.

Background/History

Historically, the fee-for-service system created financial incentives that supported competition among providers for market share. With the advent of managed care systems, the environment has changed substantially, such that few financial payors, either public or private, continue to pay providers on a fee-for-service basis. More payors are shifting financial risk to the health care provider through a system of capitated monthly payments per patient. Medicaid reimbursement to clinics, based on actual costs incurred in providing care, is scheduled to phase-out over a five-year period.

These changes are requiring rural health providers to alter the way they do business. Providers recognize that it will be difficult for stand-alone providers to survive. Consequently, providers in many communities are in various stages of building relationships, networking and entering into formal partnerships. Successful efforts will reduce duplicative services (direct patient care, ancillary and administrative) and have the potential to add new patient services. Access to and availability of health care services would be improved.

Some limitations may exist when applying a network model to the extremely rural, (so-called "frontier") areas of California. Issues of distance and demographics impact most keenly in these areas. Practitioners in the most common medical specialty areas of need, e.g., ENT, dermatology and orthopedics, are not available in these counties or are located beyond a reasonable travel distance. Moreover, the demographic incidence of needing such specialists in these regions is typically not frequent enough to financially support having specialists in a network. Nonetheless, networks may be appropriate in the less remote rural areas.

Desired Outcomes

- The rural health community would like recognition that the rural health providers are an important part of every rural community's economy, both in providing a strong employment base and in attracting new businesses and economic development to that community.
- The rural health community would like assurance that the value of services and access is recognized and supported by the State.
- The rural health community would like the State departments to facilitate support and assistance to efforts similar to some currently being developed, such as:
  - California State Rural Health Association's feasibility study of financing mechanisms, including a statewide rural Health Maintenance Organization, and
  - Pilot efforts, such as the James Irvine Foundation's three-year initiative, Developing Rural Integrated Systems (DRIS).

- The CRHPC intends that State departments will support efforts that continue to build upon and improve the provision of health care services and access in rural areas.

Possible Approaches

A. State departments could provide direct technical support and assistance to rural provider communities desiring to develop networks or form integrated delivery systems.
   PROS: Would provide a responsive resource and expertise to rural providers throughout California.
   CONS: Would require a redirection of staff and resources by departments. Expertise may not be currently available within State departments.

B. State departments could provide financial assistance that supports rural networking activities.
   PROS: Would be welcomed by many rural communities.
   CONS: Would require legislative action to appropriate new funds or change how some existing funds are currently used.

C. State departments could coordinate funding efforts with private foundations and other funders to support rural networking efforts and research.
   PROS: Would avoid duplication of funding efforts among funders. Would not require new State funding source.
   CONS: Some funders may not be willing to fund a function that they identify as a State responsibility.

3 Regulations

Summary of the Issue
Rural health providers perceive that State regulations are often designed for urban-based health providers. Moreover, their perception is that State interpretation and application of these regulations are sometimes inconsistent.

Background/History
Providers report many challenges in complying with State regulations. Most often, the need to perform multiple roles and lack of specific training may bear on the ability to "get it all done."

- Rural health providers often have multiple responsibilities in contrast to an urban setting, where one or even many individuals are charged with a single responsibility. For example, a rural hospital administrator may be responsible for a general acute care hospital, emergency room, radiology, pharmacy, laboratory, emergency medical transportation, skilled nursing facility, primary care clinic, home health services, and recruitment of clinical providers. At the same time, this person might also be the chief financial officer while the hospital recruits for a replacement.

- It is not unusual for the chief administrative person of a hospital, clinic or other health provider to have spent an entire career in one organization. Such individuals may not have the benefit of a specialized education or internship in the areas for which they find themselves responsible.

The perceived need among rural providers is to have a streamlined regulatory system that (1) reflects rural circumstances and (2) provides technical assistance and training to rural administrators. Rural providers believe that this could be accomplished without compromising quality or causing conflicts of interest.

Another issue is the providers' perception that regulations are not always consistently interpreted. The perception is that a change in State reviewers from one year to the next sometimes appears to change how the regulations are interpreted. In a similar issue, rural providers also express their need to have State reviewers with more knowledge of rural health delivery systems.

In summary, it can be said that the current regulatory and financial systems for publicly funded health care in California require a high level of accountability. This level may be difficult to achieve in rural areas because of resource and training issues.

Desired Outcomes
- The rural health community wants regulations that reflect the realities of rural health care settings, and are flexible and consistently interpreted by State staff knowledgeable about rural health delivery issues.
- The CRHPC continues to encourage State departments to provide assistance to

rural providers in complying with meeting regulations, standards and policies.

- The CRHPC continues to encourage State departments to develop appropriate and flexible interpretations that take into consideration the unique circumstances specific to rural areas, without compromising issues of health, safety and quality care.

Possible Approaches

A. State departments could include rural health providers in the development process.
   PROS: Would be responsive to requests from rural health providers.
   CONS: Urban providers may request the same level of involvement.

B. State departments could organize staff into rural health teams that are experienced and knowledgeable specialists on rural issues.
   PROS: Would help to provide a consistent and standard interpretation of regulations. Would provide technical assistance that is needed and would be welcomed by providers.
   CONS: Would necessitate organizational restructuring, specialized staff training and potential increased costs.

4 Managed Care

Summary of the Issue
The ability of rural health providers to compete successfully in a managed care environment is of concern to many rural providers.

Background/History
Currently, different forms of managed care are under rapid development in California. All of these forms were developed from urban models, in areas with the largest populations of beneficiaries and the highest number of health care providers located in very competitive markets. Whether these models are appropriate to rural settings has been questioned. Moreover, rural providers are concerned about their continued ability to operate in regions where established managed care systems are moving from their urban bases.

Of special concern to rural providers is the shift to managed care strategies for populations that are traditionally served by these providers. For instance, the Medi-Cal program has four different types of managed care programs. These were implemented on a countywide basis, including counties that have vast rural areas, often served by a few rural health providers, as follows:

1. County Organized Health Systems (4 counties with rural areas):
   San Mateo, Santa Barbara, Santa Cruz, and Solano
2. Geographic Managed Care (2 counties with rural areas):
   Sacramento and San Diego
3. Two Plan Model (10 counties with rural areas):
   Contra Costa, Fresno, Kern, Los Angeles, Riverside, San Bernardino, San Joaquin, Santa Clara, Stanislaus, and Tulare
4. Fee-for-Service Managed Care (2 counties with rural areas):
   Placer and Sonoma

In addition, California's Healthy Families Program is a statewide program covering all 58 counties, 55 of which have defined rural areas. This program began enrolling beneficiaries on July 1, 1998.

Desired Outcomes

- Rural health providers would encourage State departments responsible for the managed care programs to consider fully the financial and administrative limitations of rural health providers, as well as the impacts of managed care programs on them.
- The CRHPC supports State departments in their efforts to increase health services and access for citizens in rural areas.

Possible Approaches

A. State departments could jointly establish a monitoring/evaluation unit, focused on rural health providers and responsible for monitoring the ongoing level of services and access available in rural areas.

PROS: Would recognize the critical role of health providers in rural areas. Would create a mechanism for timely information to be gathered and presented to State department directors. Would enable the State to take positive and corrective steps in a timely manner.

CONS: Would require organizational structuring, staff training, and potential increased costs.

B. State departments could continue to hold roundtable meetings with key rural stakeholders on a regular basis to hear first hand about the impact that their programs are having on health providers in rural areas.

PROS: Would provide State departments with a vehicle for timely information and feedback.

CONS: The feedback would not be representative of all rural regions in California. Continues an anecdotal, rather than systematic, information-gathering process. Could set up false expectations among attendees that problems brought forward in roundtable sessions can be resolved.

5 Funding

Summary of the Issue
Rural health providers have limited resources and must deal with problems associated with uncompensated care and the lack of economies of scale. They often express the need for additional funding to meet the needs of their communities.

Background/History
Historically, both the federal and State government have provided funding to health providers (hospitals, clinics, county health departments, etc.), with requirements that prescribed how the funds were to be used. Most often, these requirements were formulated based upon demographic trends in urban areas, which may or may not have reflected the most pressing needs in rural areas. While rural health providers have also been recipients of these funds, the amount of their awards is often based on population formulas, which result in amounts in small counties that are not large enough to be used effectively. Also, rural providers cannot benefit from economies of scale.

In addition, as described in Issue 1 "Standards and Consolidation", these funds are categorized so that each funding stream often requires a separate contract, line item budget, data reporting requirements, auditing, and a fixed percentage of time devoted by identified members of the provider's staff. Providers report their impression that these requirements decrease the available funds for actual services.

Infrastructure funding is also undergoing changes. State and federal agencies have historically provided little in ongoing funding for equipment and capital funding. These agencies have funded services, and consider infrastructure a local responsibility. With the changing environment of managed care and reimbursement practices, providers feel that it will be increasingly difficult to generate sufficient funds through their operations to meet their capital needs.

Providers also speak of moving to performance-based outcome measures, rather than relying on the budget-based management system now in place. This concept is discussed further in Issue 8, "Outcome-based State Management."

Desired Outcomes
- The CRHPC supports efforts to identify funding sources for capital needs in rural areas, such as the recent budget augmentations for the Rural Demonstration Projects under the Healthy Families Program, $3 million from the Department of Health Services for capital and equipment grants.
- The CRHPC encourages efforts to simplify, streamline and expedite the application processes for various funding sources to the greatest extent possible.
- Rural health providers would support legislation to reduce categorical funding streams whenever possible, and to coordinate funding efforts that target rural communities.
- The CRHPC anticipates that State departments will make efforts to coordinate funding activities in rural areas to avoid duplication and to maximize the benefit

of their funding efforts.

- The CRHPC anticipates State departments will coordinate funding activities with other funders, such as private foundations.

Possible Approaches

A. State departments could assist in efforts to maximize funding opportunities available for health-related capital purposes in rural areas.
   PROS: Would strengthen and help to preserve access to health care in rural areas.
   CONS: May require State General Fund monies.

B. State departments could review and support, where appropriate, efforts to allow more discretion by rural communities in determining how funds will be used and a reduction in categorical funding streams through use of block grants.
   PROS: Would reduce administrative costs and make more funds available for direct patient care.
   CONS: Would require significant federal and State legislative involvement and could be a lengthy process to implement. Would still need adequate safeguards to ensure accountability.

C. State departments could focus on performance-measured "outcomes" that reflect improvements in the health status of rural residents.
   PROS: Would reduce administrative costs and make additional funds available for treating residents in rural areas.
   CONS: Would require consensus on what is to be measured as well as additional resources for measuring and reporting baseline data. May not be a viable approach in smallest counties because data is not statistically reliable for some data elements due to small numbers. May reduce the current level of accountability.

6 Technology

Summary of the Issue
The revolution in electronic technology has created opportunities for telehealth and telemedicine (TH/TM) applications for rural health care providers.

Background/History
A core reality of rural and frontier areas has been isolation, whether it be geographically based or a result of seasonal weather conditions, mud slides, washed out roads and bridges, fires or other natural disasters.

Rural health care professionals are also isolated in many ways. Many express that they find themselves isolated from their colleagues, on-call twenty-four hours a day, unable to participate in many continuing medical education classes (which are usually held in urban areas), and unable to refer their patients to local specialists because so few of these practice in rural areas.

Clinical charts, diagnostic test results, administrative records, financial reports, data reports, billing, purchasing and accounts receivable may be done manually in rural clinics, without the benefit of any computerization. Meanwhile, advances in the ability to send high quality images between physicians or to hold two-way video consultations are resulting in changes to health care delivery not even considered a few years ago.

Currently, many developments are taking place in the TH/TM field:

- Utility companies are actively expanding the availability of T1 and Integrated Services Digital Network (ISDN) fiber optic telephone lines that will provide the core infrastructure to make high-speed transmissions and connection to the Internet possible. The federal government has made $400 million available to health providers, libraries and schools in rural areas to offset the telephone line charges incurred in connecting to the Internet.
- The Sierra Health Foundation is providing three-year funding that supports the California Telehealth Telemedicine Center (CTTC), based at the California Healthcare Association offices in Sacramento. The Resource Center recently awarded $225,000 for five TH/TM grants in Bieber, Dorris, Downieville, Susanville and Sonora.
- Recently passed State legislation (Chapter 310/1998) further allows providers to bill Medi-Cal for patient care, when using store-forward and other telemedicine technologies that meet a specified standard.
- The Managed Risk Medical Insurance Board (MRMIB) has awarded Blue Cross of California a $1.85 million grant to address the needs of subscribers in the Healthy Families Program in rural areas through the use of telemedicine. Blue Cross will be partnering with the University of California, Davis, and Cedars-Sinai Health Systems in expanding existing sites and establishing 20 additional sites in rural areas across the State.

Many State departments, e.g., the Departments of Corrections, Developmental Services, Aging, Health Services, and Education, and the University of California, have either implemented TH/TM systems or are in the process of developing them individually. Collaborative efforts to build these systems would be in the best interests of all parties.

Desired Outcomes

- The CRHPC anticipates that its member departments will assist, whenever possible, in identifying funding sources for rural health providers that will enable them to purchase, install and develop operational TH/TM systems.
- The rural health community urges State departments to develop new and/or modify existing regulations that will allow providers of telemedicine to be reimbursed for patient care.
- Rural health providers support efforts among State departments to assume a leadership role in the development, application and expansion of TH/TM activities.
- Rural health providers support the establishment of a "focal point" within State government that can provide technical assistance to rural health providers, and will work in collaboration with the California Telehealth Telemedicine Center or other agencies developing this capacity in rural areas.

Possible Approaches

A. State departments could review pertinent reimbursement regulations and policies in order to expand reimbursement to health providers using this new technology.

PROS: Would potentially improve the quality of care and health outcomes for covered patients in rural areas. Could provide financial incentives to providers using this new technology.

CONS: There is no complete financial analysis on the net cost difference to the State of existing practices versus using TH/TM. Would require additional staff time and resources. State departments may not currently have this expertise.

B. State departments could jointly develop TH/TM services that are mutually compatible and support each other's activities.

PROS: Would make a cost effective and efficient use of scarce resources and enable State departments to develop partnerships.

CONS: Would require additional staff time and resources. State departments may not currently have this expertise.

7 Program-Specific Reviews

Summary of the Issue

Health care delivery in rural areas may benefit from a review of certain programs. Rural counties believe that State departments could recognize the administrative and staffing limitations and lack of economies of scale present in small counties, and provide flexibility to these areas, without compromising the goals of individual programs.

Background/History

Small counties report difficulties in complying with the State requirements of specific programs. For instance, they raise concerns about the program staffing requirements that appear to be designed for large counties with sufficient depths of staff to meet those requirements.

Desired Outcomes

- The rural health community urges State staff to work together with rural areas on the limitations of small counties in complying with requirements designed for larger counties with greater resources, and to be willing to provide flexibility to small counties.

Possible Approaches

A. State staff could be responsible for seeking exceptions or waivers in the application of program requirements to small counties participating in some programs.
   PROS: Would be responsive to small county fiscal limitations.
   CONS: May increase State staff time in seeking exceptions/waivers and in negotiating agreements with small counties.

B. State program staff could continue to solicit and incorporate comments from rural county focus groups when drafting requirements for new or re-designed programs.
   PROS: Would help to assure that small counties could meet program requirements and prevent problems before they arise. Would promote public participation in the development process.
   CONS: May increase State staff time if large counties request like similar consideration.

8 Outcome-Based State Management

Summary of the Issue

Many in the rural health community would prefer State departments to focus more on the positive and lasting impact that their programs and funding have on rural residents and communities, and less on administrative, budget and process-related activities as indicators of program success.

Background/History

State departments administer approximately one hundred different health-related programs, each with its own requirements for contracting, invoicing and auditing. Most of these programs tie performance to output indicators, such as the number of patient visits, client encounters, vouchers or caseload counts. Often, such data is used to calculate future funding allocations for programs. If entities do not report this data, their financial situation suffers.

Rural providers report the lack of performance indicators that go beyond the output statistics and that would, instead, measure impact on the health status of the person served and/or the community as a whole. However, these indicators are not without problems where populations and incidences are too small to be statistically reliable. This problem exists in the smallest counties for some of the data elements currently reported for Healthy People 2000. In addition, equity issues invariably arise concerning the fairness of what is to be measured, as well as the accuracy and timeliness of the data itself. The difficulty of achieving consensus on what is to be measured and the increased costs associated with data collection cannot be overlooked.

As an alternative, the rural health providers may consider a system of performance indicators that target productivity and quality of care. Program review efforts that focused on cost-per-visit data have been used successfully in the past, leading to improvements in the provider's fiscal self-sufficiency and cost effectiveness.

Desired Outcomes

- The CRHPC supports the use of administrative processes and data that will contribute to better service delivery, and ultimately to the improved health status of California rural residents, while maintaining fiscal and other accountability standards.

Possible Approaches

A. State departments could explore the use of alternative performance indicators in contracts with rural providers.
   - PROS: Program focus would be on health outcomes and the contribution that programs make. Rural communities and State departments would determine if the program impact could be measured through data.
   - CONS: Would require research and consensus on what should be measured. Could add workload to the local level unless current reporting could be reduced. Would require increased State staffing.

B. State departments could provide technical assistance to rural communities in identifying the importance of data collection and its relevance to the funding of State programs.

PROS: May improve some counties' current data collection efforts and consequently their future revenue streams.

CONS: None identified.

9 Transportation

Summary of the Issue

Rural residents needing medical care are frequently unable to access care because they have no transportation to the nearest medical facility. In extreme cases, they sometimes resort to calling an ambulance, which makes the Advanced Life Support/Basics Life Support (ALS/BLS) unit unavailable for true emergencies and is the highest cost method of transportation within our health care system.

Background/History

Rural areas throughout California are challenged daily by the lack of non-emergency transportation for health care. This issue is mentioned repeatedly by rural residents and by the health care providers upon whom they rely. In many communities, persons needing non-emergency clinical services will drive if they have a car, get a ride from a neighbor, hitchhike, walk, call the sheriff or police, ask for a home visit, or in extreme circumstances, call an ambulance.

However, part of the problem may be resolved with further research into the issues and by creative collaboration methods. For example, the Trinity County Health Care Task Force looked at barriers that they thought prevented them from sharing transportation resources across departments. Finding these to be fewer than they had thought, the Task Force developed a Joint Powers Agreement with departments that each provide some type of transportation. This collaborative effort will allow persons needing transportation to access transportation from any of the participating departments.

This example from Trinity County provides insight into the rural transportation issue in general; that is, the lack of transportation resources is not limited to the health care sector but extends across most rural service sectors as well. Perhaps the focus should not be to solve health care transportation shortages, but to look at a broad range of rural service systems and to explore linkages to CALTRANS resources for planning local transportation systems. For instance, using provisions of Section 5311 of the Federal Transit Act, Fresno County has developed a Rural Transit Agency with nineteen subsystems, running a combination of demand responsive and scheduled fixed routes.

Desired Outcomes

- The CRHPC is committed to encouraging State departments to recognize and understand the transportation issues impacting residents of rural areas of California, and to facilitate adoption of innovative efforts to improve patient transportation in rural areas.

Possible Approaches

A. State departments could help local agencies take advantage of all funding opportunities that would have a positive impact on addressing transportation issues.
   PROS: Would increase the funding base in rural areas.
   CONS: Would require State resources to track funding opportunities.

B. The Trinity County Health Care Task Force model could be tracked and, if successful, could be promoted by the State in other rural communities.

PROS: If successful, would be a low-cost alternative to replicate in other rural communities.

CONS: Would require some resources to study the outcome of this model. This model relies on high levels of cooperation and collaboration.

C. The CRHPC could direct the Interdepartmental Rural Health Coordinating Committee to establish a working relationship with CALTRANS staff to explore opportunities for linking health services with regional transportation planning efforts.

PROS: Would support local planning efforts. May help to avoid duplication of efforts at local level.

CONS: Would require some resources to coordinate with CALTRANS. Regional transportation planning may still be impossible in remote areas, and may only work in the mixed urban-rural areas as found in Fresno County.

10 Strategic Planning for Local Communities

Summary of the Issue
Rural communities recognize the value of strategic planning for their communities, but often do not have the resources or expertise locally to conduct it.

Background/History
For many years, health providers in rural communities have described functioning mostly in a reactive mode. Often these same communities do not have the resources or expertise necessary to formulate a plan that moves the community into a pro-active mode, where it can anticipate and plan in advance for its projected needs.

Rural communities have expressed interest in developing and implementing strategic plans, but are often unable to realize their goal of producing tangible, usable planning documents. In recent efforts, private foundations have established long-term funding support for rural efforts to integrate local health care delivery systems. For example, the James Irvine Foundation is providing three-year funding to five DRIS communities (Imperial, Ridgecrest, Lompoc, Humboldt and Siskiyou) to support a community-based planning process among provider networks. More public-private collaborations of this kind may be a possibility worth exploring.

Similar to findings in Issue 8, "Outcome-based State Management", the rural health community has expressed the need for assistance in developing reliable data and the systems to support ongoing data collection. Such data is fundamental to successful planning efforts, and efforts to improve the rural communities' access to more user-friendly data would be welcome.

Desired Outcomes
- The CRHPC acknowledges the value of having rural communities participate in a strategic planning process and produce written strategic plans.
- The rural health community expresses the need for either State financial support or direct technical assistance for the development of strategic plans in rural communities or regions.
- The CRHPC encourages State departments to explore development of a "boilerplate" strategic plan that could be used by rural communities in guiding their efforts and could serve to "standardize" the final product from one rural community to another.

Possible Approaches
A. State departments could provide funding to assist rural communities in developing strategic plans, or alternatively, work with private foundations to focus their efforts in this area.
   PROS: Would provide the funding to make strategic planning a reality in rural areas.
   CONS: Would require new or redirected resources from State funding, if private sources could not be secured.

B. State departments could provide technical assistance to rural communities in developing strategic plans.

PROS: Would provide the assistance that rural communities need in order to prepare strategic plans.

CONS: Would require new funds or a redirection of existing staff, resources and expertise.

C. State departments could help establish a network of urban-rural partnerships, where the urban partner agrees to provide strategic planning assistance to the rural partner.

PROS: Would provide the assistance that rural communities need in order to prepare strategic plans. Would require fewer resources from State departments.

CONS: May not be seen as an appropriate source of assistance by rural communities.

D. State departments could work on improving data collection systems and make more user-friendly data available to rural communities.

PROS: Would provide basic tools for better strategic plans.

CONS: Would require some redirection of existing staff, resources and expertise.

11 Communication

Summary of the Issue

The lack of effective cross-department communication and coordination on rural health activities among federal, State and local departments adversely impacts rural communities.

Background/History

State departments have historically operated in relative independence from one another. The California Rural Health Policy Council and its Interdepartmental Rural Health Coordinating Committee were established in order to create a forum that promotes communication, coordination and collaboration, and reduced fragmentation.

In addition, rural communities report frustration when accessing State agencies. The Policy Council has provided a focal point of contact to ensure that rural officials and providers find such access and are responded to promptly.

Desired Outcomes

- The CRHPC anticipates that State departments will continue to work together in a collaborative, team approach.

- The rural health community urges State departments to include rural providers and health care associations, to the greatest extent possible, in discussions prior to decisions being made.

Possible Approaches

A. The CRHPC anticipates that IRHCC representatives will continue to keep each other informed on a regular basis about all rural health activities in which they are involved.
   PROS: Would continue close communication and coordination, thereby reducing duplication of efforts. Would improve the knowledge and understanding of IRHCC members.
   CONS: None identified.

B. The IRHCC could invite key rural health constituencies to collaborate and consult with IRHCC members on special projects.
   PROS: Would improve communication with constituencies and result in IRHCC decisions and work products that are reflective of the end users' needs.
   CONS: May require extra time and training for individuals who have not worked on inter-governmental collaborative projects.

12 Workforce Availability

Summary of the Issue
Rural health providers face difficulties in recruiting clinical providers and experienced, knowledgeable administrative staff. Even if providers are successful in recruiting such individuals, the providers then face the challenge of retaining them.

Background/History
Providers of health care in rural areas report the difficulties with recruitment and retention of experienced, knowledgeable and competent staff. They must compete against their non-rural counterparts who generally offer higher compensation, better benefit packages, shopping centers, cultural activities and educational opportunities.

Professional isolation is also a continuous factor. Although not a total solution, the development of telehealth and telemedicine in rural areas is hoped by many to reduce isolation and enable practitioners to communicate and consult with their colleagues in other locations.

To assist providers with recruitment of primary care physicians and mid-level practitioners, State agencies fund (1) programs that certify preparation of practitioners for rural areas, and (2) programs that reimburse the training costs of the practitioners. For example, the Office of Statewide Health Planning and Development provides financial incentives through the Song-Brown Program for family practice physicians in residency, as well as student loan repayment programs through the National Health Service Corps and the State Loan Repayment Program. The California Health Manpower Policy Commission identifies shortage areas in the State for physicians and mid-level medical practitioners.

Moreover, rural health providers' recruitment and retention challenges are not only with medical practitioners. Many providers experience great difficulty in recruiting administrators and chief executive officers, financial officers, maintenance personnel, billing clerks, mental health professionals (e.g., psychiatrists, psychologists, and licensed clinical social workers), dental professionals, physical/occupational/recreational/speech therapists, pharmacists, and laboratory or radiology technicians.

In order to assist these rural providers in their recruitment efforts, the CRHPC Office designed and operates a "Rural Jobs Available" service, connected to 46 other states, that lists all employment opportunities with rural health providers

Desired Outcomes

- The CRHPC encourages State departments to continue efforts that improve the recruitment and retention of health professionals in rural areas of California.

- The CRHPC supports regulation, reimbursement and funding strategies that encourage the development and application of technologies, e.g., telehealth and telemedicine, aimed at solving workforce and service availability issues in rural areas.

- The CRHPC recognizes that non-clinical individuals may be just as critical to the operations of the health provider as those providing direct patient care.

Possible Approaches

A. State departments could undertake a short-term study to identify State programs involved in workforce supply for rural health providers, and encourage those programs to coordinate their efforts.

PROS: Would be cost effective, improve efficiency, and provide a coordinated effort that would be identified and more easily available to universities, community colleges, trade schools, rural health providers and job seeking individuals.

CONS: Would require limited redirection by departments to devote staff time to this effort.

B. State departments could conduct a consolidated survey on projected workforce needs in rural health communities to identify the key challenges.

PROS: Would provide a focused direction for State departments to take that would be responsive to the future workforce needs in rural areas.

CONS: Would require staff efforts or other resources to conduct this research, analyze the results, formulate recommendations, and present alternatives for approval and implementation.

- The rural health community urges legislation that recognizes the needs and constraints of rural health providers, by considering flexibility of staffing requirements and scope of practice requirements.
- The rural health community encourages community colleges to offer courses through multiple means, e.g., on campus, distance learning, satellite or downlink, in career areas needed by rural health providers.

Interdepartmental Rural Health Coordinating Committee (IRHCC)
Current Composition

- Department of Health Services:
    - Audits and Investigations
    - Health Information and Strategic Planning
    - Licensing and Certification
    - Medi-Cal Policy
    - Office of County Health Services
    - Primary Care and Family Health

- Office of Statewide Health Planning and Development:
    - Director's Office
    - Primary Care Resources and Community Development Division
    - Cal-Mortgage Loan Insurance Division
    - Facilities Development Division

- Department of Alcohol and Drug Programs

- Emergency Medical Services Authority

- Department of Mental Health

- Managed Risk Medical Insurance Board

The department directors sitting on the California Rural Health Policy Council determine interdepartmental Rural Health Coordinating Committee membership. Participation on the Coordinating Committee is encouraged and is open to other state departments/ agencies in addition to those constituting the California Rural Health Policy Council.

List of Acronyms

3R-Net	National Rural Recruitment and Retention Network
AB	Assembly Bill
ADP	Department of Alcohol and Drug Programs
ALS	Advanced Life Support
BLS	Basic Life Support
CA	California
CHA/RHC	California Healthcare Association /Rural Healthcare Center
CHEAC	County Health Executives Association of California
CY	Calendar Year
CMSP	County Medical Services Program
CRDC	California Rural Development Council
CSRHA	California State Rural Health Association
CTTC	California Telehealth Telemedicine Center
DHS	Department of Health Services
DMH	Department of Mental Health
DRIS	Developing Rural Integrated Systems
EMSA	Emergency Medical Services Authority
ENT	Ear-Nose-Throat
FQHC	Federally Qualified Health Center
FSR	Feasability study report
FY	Fiscal Year
HCTF	Health Care Task Force (Trinity County)
HHSA	Health and Human Services Agency
HMO	Health Maintenance Organization
HPSA	Health Professional Shortage Area
IRHCC	Interdepartmental Rural Health Coordinating Committee
ISDN	Integrated Services Digital Network
MRMIB	Managed Risk Medical Insurance Board
MSSA	Medical Service Study Area
OSHPD	Office of Statewide Health Planning and Development
PL	Public Law
RCAC	Rural Community Assistance Corporation
RCRC	Regional Council of Rural Counties
RFA	Request for Application
CRHPC	California Rural Health Policy Council
T1	Transmission medium (Digital Signal Level One)
TH/TM	Telehealth/Telemedicine
YTD	year-to-date

2nd Annual Report to the California Legislature
READER'S FEEDBACK AND RESPONSE

- We hope to improve and expand the usefulness of this Annual Report.
- We would be grateful if you would take a few minutes and provide us with your comments and suggestions? Thank you.

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What I like about this report is:

Ways that you could improve this report are:

Other comments:

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Sacramento, CA 95814

Or FAX to: (916) 654-2871